DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: Maternity Support Services/
Infant Case Management Providers
Managed Care Plans

Memorandum No: 04-24 MAA
Issued: May 10, 2004

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration (MAA)

For Information Call:
1-800-562-6188

Subject: Maternity Support Services/Infant Case Management – Reimbursement Rate Revisions

Retroactive to dates of service on and after October 1, 2003, MAA is revising the maximum allowable fees for the Maternity Support Services/Infant Case Management (MSS/ICM) program.

Maximum Allowable Fees

Retroactive to dates of service on and after October 1, 2003, MAA is increasing the maximum allowable fees for the MSS/ICM program to more accurately reflect targeted program expenditures. Attached are revised replacement pages to the Maternity Support Services/Infant Case Management (MSS/ICM) Billing Instructions, dated October 2003.

Adjustment to Paid Claims

For paid claims with dates of service from October 1, 2003 through April 30, 2004, MAA will automatically adjust any claims that were paid at the lower rates by using a gross adjustment process. The gross adjustment will be reported to each provider on an upcoming Remittance Advice (RA) as one lump-sum payment. Each provider will receive individual documentation showing the number of adjusted claims covered by the gross adjustment.

Note: **Do not** submit an adjustment request for any MSS/ICM claims for the above dates that were paid between October 1, 2003 and April 30, 2004.

If you submit an adjustment request, for claims paid during the period referenced above after MAA has issued a gross adjustment, you will be subject to audit findings and recoupment.

Adjustment to Claims Not Yet Paid

For any claims with dates of service prior to May 1, 2004 that were not yet paid at the time of gross adjustment, you must submit an adjustment request. Please refer to your remittance advice to identify which claims were paid after May 1, 2004 at the non-adjusted rate. To receive reimbursement at the revised level, you will need to initiate the adjustment and make sure that the billed amount on the adjustment form is at least equal to MAA's revised rates, if necessary.

MAA will not adjust any claims with dates of service on and after May 1, 2004. If your billed charges are less than the revised maximum allowable fees, you must submit an adjustment form for these claims in order to receive additional reimbursement. Your billed charges must be at least equal to the new rates in order to receive the full reimbursement amount.

To obtain DSHS/HRSA provider numbered memoranda and billing instruction, go to the DSHS/HRSA website at http://hrsa.dshs.wa.gov (click ***the Billing Instructions and Numbered Memorandum*** link). These may be downloaded and printed.

Billing for Integrated MSS

- **Bill MAA using the mother's Patient Identification Code (PIC) found on the DSHS Medical Identification Card.**

- MSS providers must have an individual face-to-face contact with the pregnant/post pregnancy client before billing any of the integrated MSS/ICM services in the fee schedule, **except** the Family Planning Performance Measure (procedure code T1023 with modifier HD). The Family Planning Performance Measure is not included in the maximum of 60 units.

- An initial face-to-face visit may be billed to MAA without a signed consent form if the client refuses further services as long as this refusal is documented in the chart. Only services provided to the pregnant/post-pregnancy woman may be billed.

- Travel, charting, and phone calls are included in the reimbursement of each MSS procedure code.

- Community health nursing visits, nutrition visits, behavioral health visits, and community health worker visits ~~and Doula visits~~ are subject to the following ***limitations*** per client:

- One **unit** equals **15 minutes**

  - ✓ A minimum of 2 units must be provided per day for billed home visits;
  - ✓ A maximum of 6 units may be billed per day for any combination of office and/or home visits; and
  - ✓ A maximum of 60 units from all disciplines combined may be billed for office and/or home visits over the maternity cycle (pregnancy through two months post-pregnancy). ~~; and~~
  - ~~✓ A maximum of 18 units may be billed for Doula visits over the maternity cycle (Doula visits count towards the maximum of 60 units).~~

- If the mother becomes pregnant again within 12 months from the previous pregnancy, enter the new "Due Date" in field 19 on the HCFA-1500 claim form for new MSS services. This "resets" the claims processing clock for the new pregnancy.

Fee Schedule for Integrated Maternity Support Services

Effective for dates of service on and after October 1, 2003:

Use the most appropriate diagnosis code (such as V22.2) when billing for the following procedure codes:

Procedure Code/ Modifier	HCPCS Description	Old State-Unique Code Description	Office Visit	Home Visit
T1002 HD	RN services, up to 15 minutes **1 unit = 15 minutes**	MSS Community Health Nursing Visit	$30.00	$40.00
S9470 HD	Nutritional Counseling, dietician visit **1 unit = 15 minutes**	MSS Nutrition Visit	$30.00	$40.00
96152 HD	Intervene hlth/behave, indiv **1 unit = 15 minutes**	Psychosocial Visit	$30.00	$40.00
T1019 HD	Personal Care Services, per 15 minutes (Community Health Worker) **Not in a hospital 1 unit = 15 minutes**	Community Health Worker Visit	$15.00	$20.00
~~S5125 HD~~	~~Attendant Care Services, per 15 minutes [Doula] **1 unit = 15 minutes** *~~	~~N/A~~	~~$9.00~~	~~$15.00 (home or hospital visits)~~

* Effective for claims with dates of service on and after April 1, 2004, MAA will no longer reimburse providers for Doula services

What services are covered under ICM?

MAA reimburses approved providers on a fee-for-service basis for case management under the ICM program including:

- Assessing risk and need;
- Reviewing and updating the infant and parent(s) service plan;
- Referring and linking the client to other agencies; and
- Advocating for the client with other agencies.

The case management activities listed above are covered under the ICM program only when:

- Documented in the client's record;
- Performed by a qualified staff person acting within his or her area of expertise; and
- Used according to program design as described in the MSS/ICM Assurances (included in Provider Application Packet).

Billing for ICM

Bill MAA for ICM services using the baby's Patient Identification Code as listed on the baby's DSHS Medical ID card. Do not use the mother's PIC.

ICM is considered family-based intervention. Therefore, the infant [and family] are only allowed one Title XIX Targeted Case Manager at a time.

The most common examples of duplicate services include nursing intervention services for families at risk for child abuse and neglect through a state contract between DSHS, Children's Administration, Child Protective Services (CPS) and local health jurisdictions; Children with Special Health Care Needs; and HIV/AIDS.

Travel expenses, charting time/documentation, phone calls and mileage are included in the reimbursement rate for ICM.

ICM is provided for mother/newborn meeting eligibility criteria. (Services can be provided from the end of the maternity cycle to the newborn's first birthday.) The following *limitations* per client apply:

One unit equals 15 minutes

- A maximum of 6 units may be billed per month; and
- A maximum of 40 units may be billed during the 10 months following the maternity cycle.

What if the client becomes pregnant again before ICM ends?

Enter the new "Due Date" in field 19 on the HCFA-1500 claim form. This "resets" the claims processing clock for the new pregnancy. All future visits/billing will be for the new pregnancy using MSS procedure codes. You may no longer bill under the Infant's PIC number or for ICM codes

How do you bill for ICM if there was a multiple birth?

ICM is billed using one of the infants' PIC numbers. ICM is a family service and must not be billed for each individual infant.

Fee Schedule for ICM

Effective for dates of service on and after October 1, 2003:

Procedure Code/ Modifier	Diagnosis Code	HCPCS Description	All Settings Maximum Allowable
T1017 HD	V20.1	Targeted Case Management, each 15 minutes 1 unit = 15 minutes	$ 25.00